Counseling and Care Management Services, LLC

Client Registration

Client Name: _____Date of Birth: _____
Address:_____
City: _____State: _____
Zip Code: _____ Home Phone ▫_____CellPhone▫_____
Email address:_____
Emergency Contact or Legal Guardian: _____Phone:_____

INSURANCE INFORMATION
Insurance Company: _____ Phone Number:_____
Group Number: _____
Policy Holder's Name:_____Date of Birth:_____
Member Identification Number: _____
Policyholder Social Security Number_____
Relationship to Client: _____
Policyholder's Employer: _____

Initial below:
_____ I understand that I am personally responsible for fees not paid by my insurance and payment of my bill is my legal obligation.
_____ I have read the fee policy of Counseling and Care Management Services, LLC. I agree to be ultimately responsible for the balance on the account for services rendered.
_____ I acknowledge that I have been provided a copy of, or have been offered the opportunity to receive from Counseling and Care Management Services, LLC notice of Privacy Practices (HIPPA).
_____ I authorize the release of my medical information to physicians, insurance companies and medical supplier and persons on my intake form.

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Signature of client (or responsible party) Date